(When Filled In)

CLAIM FOR DEPENDENT MEDICAL CARE

EMPLOYEE DATA

1. NAME OF EMPLOYEE (Last-First-Middle)	2. DATE OF BIRTH	3. EMPLOYEE STATUS

4. DUTY STATION

DEPENDENT DATA

5. NAME OF DEPENDENT (Last-First-Middle)

6. RELATIONSHIP TO EMPLOYEE	7. SEX	8. AGE

9. DATE DEPARTED U.S.	10. DATE OF ARRIVAL ABROAD

11. DATE OF DEPARTURE FROM OVERSEAS	12. DATE OF ARRIVAL IN U.S.

13. NATURE OF ILLNESS OR INJURY

13A. CAUSE OF ILLNESS OR INJURY

14. WAS DEPENDENT ADMITTED TO A HOSPITAL FOR IN-PATIENT CARE?		YES		NO

15. IF YOU HAVE ANSWERED "YES" FOR ITEM 14 ABOVE, FURNISH NAME AND ADDRESS OF HOSPITAL

16. IF YOU HAVE ANSWERED "NO" TO ITEM 14 ABOVE, INDICATE NATURE OF TREATMENT OBTAINED AND REASONS WHY DEPENDENT WAS NOT HOSPITALIZED

17. NAME AND ADDRESS OF ATTENDING PHYSICIAN

18. AMOUNTS CLAIMED $	(ITEMIZE AND ATTACH BILLS AND RECEIPTS)
19. EXACT DATES OF HOSPITALIZATION (Admission & discharge)	20. INCLUSIVE DATES UNDER PHYSICIAN'S CARE

21. IS DEPENDENT COVERED BY ANY HOSPITALIZATION OR MEDICAL INSURANCE PLAN?		YES		NO

22. IF YOU HAVE ANSWERED "YES" TO ITEM 21, GIVE NAME AND ADDRESS OF INSURANCE COMPANY AND STATE WHETHER CLAIM HAS BEEN SUBMITTED TO THAT COMPANY AND ACTION TAKEN ON THE CLAIM

CERTIFICATION

I hereby certify that the above statements are true to the best of my knowledge and belief and that the amounts claimed in item 18 above do not include amounts paid or payable by any insurance company with which the above-named dependent is insured.

I further certify that the illness or injury described above was not the result of vicious habits, intemperance or misconduct on the part of the above-named dependent and claim is made for reimbursement of the amounts indicated in item 18.

23. DATE	24. SIGNATURE OF DEPENDENT (If adult)
25. DATE	26. SIGNATURE OF EMPLOYEE